These notes refer to the Health Act 1999 (c.8) which received Royal Assent on 30 June 1999

HEALTH ACT 1999

EXPLANATORY NOTES

COMMENTARY ON SECTIONS

Part II - the National Health Service: Scotland

Sections 46 to 49: NHS trusts

294. These sections enable the establishment of primary care NHS trusts in Scotland which will bring together community health services, primary care and mental health within a single organisation. They also provide NHS trusts with greater powers in dealing with their estate. This is intended to improve integration and co-ordination of primary and community health services and the provision of organisational support for GPs and other primary care providers. Through the establishment of Local Health Care Co-operatives (see commentary on section 45) the new organisations will also enable GPs and other primary care staff to become involved in the development and management of services. The new organisations will be governed by the existing legislative provisions relating to NHS trusts (as amended by the Act). In general there will be one primary care NHS trust in each Health Board area.

295. *Section 46* mirrors section 13, achieving the same result for Scotland as section 13 does for England and Wales regarding the establishment of NHS trusts (see the commentary on section 13 for background detail).

296. Subsection (1) provides a new function for NHS trusts. It permits the Secretary of State for Scotland to establish NHS trusts to provide goods and services for the purpose of the health service. In addition, the Secretary of State will be able to confer, in an NHS trust's establishment order, a duty to provide particular goods or services, at or from particular hospitals or facilities. This includes responsibility for services under Part II of the 1978 Act. These Part II services, also known as family health services, are: general medical services; general dental services; general pharmaceutical services; and general ophthalmic services. Primary care NHS trusts will be able take on the responsibility for a range of functions currently carried out by Health Boards including: making arrangements with suitably qualified Part II practitioners to supply services in their area; ensuring that patients have access to family health services; associated functions relating to the remuneration and discipline of practitioners and the development of primary care services. The intention is that primary care NHS trusts with responsibility for these functions, will be able to develop community and primary care health services in an integrated way.

297. Although it is intended to delegate to primary care NHS trusts the day to day operational functions relating to Part II services, Health Boards will continue to have a responsibility for the overall planning of primary care services. This will be achieved, as now, through Health Boards exercising on behalf of the Secretary of State the duty in section 18 of the 1978 Act to secure the provision of Part II services.

298. *Section 47* inserts a new section 12AA in the 1978 Act which provides for the delegation of Part II services, currently the responsibility of Health Boards, to NHS trusts. For each Board, functions will be delegated to the NHS trust designated by direction of the Secretary of State. This will be the relevant primary care NHS trust established to

provide services in the Board's geographic area. In most cases there will be only one primary care NHS trust in each Health Board area, but where there is more than one (as is proposed for Argyll & Clyde and Lothian Health Boards), the Secretary of State will be able to designate which trust will have responsibility for Part II services in which particular area. Where there is no primary care NHS trust (as in Shetland, Orkney and Western Isles Health Boards), Part II services will continue to be the responsibility of the Health Board.

299. *Section 48:* The White Paper *Designed to Care* signalled the intention to modify the existing arrangements for NHS trust boards as part of the new proposals. Provisions for the broad composition of NHS trust boards are set out in section 12A(3) of the 1978 Act. This provides that an NHS trust board is a body corporate with a board of directors consisting of a chairman appointed by the Secretary of State, and executive and non-executive directors. Section 48 amends section 12A(3)(a) of the 1978 Act to provide that in future non-executive directors will be known as "trustees". Regulations made under section 12A(5) allow the Secretary of State to specify the maximum and minimum numbers of members of the trust board. The power is likely to be used to specify that an NHS trust board must have not more than 5 executive directors (who are employees of the trust) and not more than 5 non-executive trustees. In the case of NHS trusts which are teaching hospitals, however, an extra trustee will be appointed to represent the relevant university. The overall intention is to broaden the range of those who can be appointed to act as trustees.

300. *Section 49:* The current direction-giving powers in respect of NHS trusts are conferred by paragraph 6 of Schedule 7A to the 1978 Act and relate to a limited number of very specific matters. Section 49 replaces these powers of direction with a general power, in line with that relating to Health Boards, which enables directions to be given in relation to the full range of NHS trusts' functions. The Government intends to use this power to meet the commitment in the White Paper *Designed to Care* to ensure that the NHS trusts manage their estate in ways which are consistent with local strategic plans.